

PERIODONTAL

Mark Forrest, D.M.D.
Periodontics & Implantology

Name (*print*) _____ Date _____

1. What is the main reason that you made an appointment in our office? _____

- | | YES | NO |
|---|--------------------------|--------------------------|
| 2. Are you having any particular dental problem?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please specify _____ | | |
| 3. Are you happy with the appearance of you teeth and gums? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. What are your main dental concerns at this time?
<input type="checkbox"/> Difficulty eating <input type="checkbox"/> Discomfort <input type="checkbox"/> Health <input type="checkbox"/> Prevention
<input type="checkbox"/> Fear of loss of teeth <input type="checkbox"/> Appearance of face <input type="checkbox"/> Other: _____ | | |
| 5. In your opinion what is your general dental condition?
<input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Neglected | | |
| 6. Have you noticed any areas of gum recession in your mouth? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you satisfied with the appearance of you teeth and gums?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Have you ever had a consultation with a periodontist before? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you ever had periodontal treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have you ever had <i>scaling and root planing</i> (deep cleaning) ? | <input type="checkbox"/> | <input type="checkbox"/> |

- If yes, when? _____
- | | | |
|---|--------------------------|--------------------------|
| 11. Are any of your teeth painful now?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do your gums bleed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Are you conscious of a bad taste or bad breath?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Do you breathe through your mouth most of the time?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you clench or grind your teeth during the day or night?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Do you have any jaw pain or clicking when chewing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Are there any foods that you have difficulty chewing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you noticed shifting of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever had orthodontic treatment (braces)?..... | <input type="checkbox"/> | <input type="checkbox"/> |

20. Name of your **present** general dentist: _____

How long have you been under his/her care? _____

21. When was your last dental cleaning? _____

When was the last one before that? _____

22. Name of your **previous** general dentist: _____

City: _____

When was the last time you saw him/her? _____

How long were you under his/her care? _____

23. Why did you change dentists? _____

24. Do you have any dental insurance? Yes No

If yes, please specify _____

Do you have more than one dental insurance? Yes No

If yes, please specify _____

(Over)

1. Do you use a hand toothbrush? Yes No

If yes, is it? Soft Medium Hard

2. What brushing technique do you use?

- Up & down
- Side to side
- Circular
- Roll
- Other: _____

3. Do you use any of the following?

- Sonicare® toothbrush How long have you been using it? _____
- Electric toothbrush How long have you been using it? _____

4. How many times a day do you brush your teeth? 1 2 3 4 times/day

5. Do you use dental floss? Yes No

If yes, how often do you use it? _____

How long have you been doing this? _____

Has anyone ever taught you how to properly use it? Yes No

6. What other items do you use to clean your teeth?

- Floss threaders
- Floss holder
- Proxabrush
- Sulcus brush
- Superfloss
- Hydro flosser
- Water Pik
- Other: _____

I understand that the fees for periodontal treatment that may be done for me by DR. FORREST are my responsibility. Even if I have dental insurance, I will pay my annual deductible, and an estimated percentage of the total charges. If for any reason my insurance company does not pay the claim, or pays a smaller portion than anticipated, I acknowledge that I am responsible for all amounts not paid by insurance.

I hereby authorize that my dental insurance payments are made directly to DR. MARK FORREST, otherwise payable to me.

I am aware that I will be responsible for scheduled appointments. I understand that after two consecutive appointments are broken, a fee will be charged.

All account balances due more than 60 days will bear an interest rate of 1½% per month, or \$5, whichever is greater. I agree that should this account be referred to an attorney or agency for collection that I will be responsible for all collection costs, attorney fees and court costs.

Signature of responsible party: _____ Date: _____